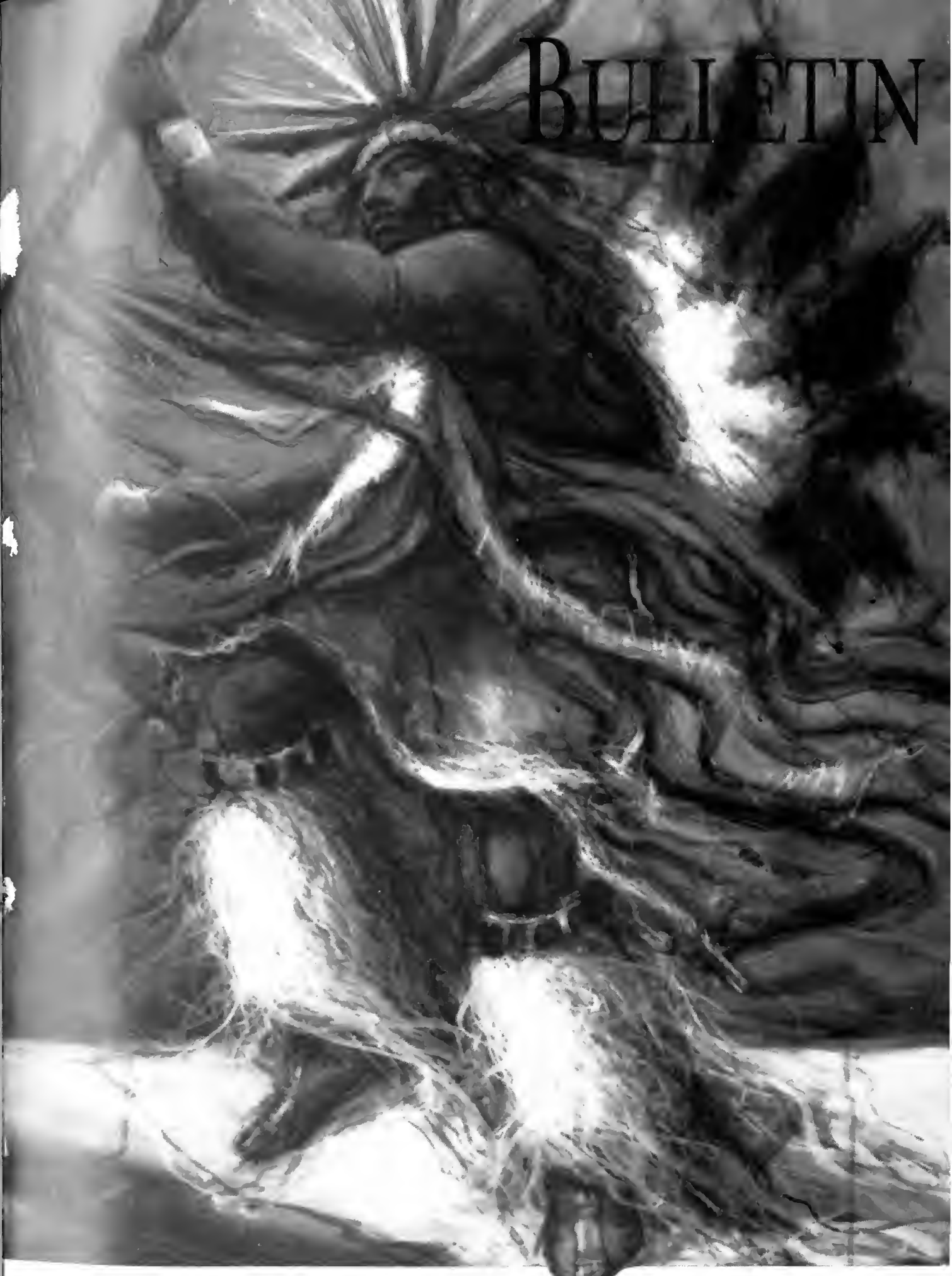
BULLETIN



BULLETIN OF THE MAHONING COUNTY MEDICAL SOCIETY VOL. 64 NO. 1 JAN./FEB. 1994

We would like to thank those of you who have contributed to *The Bulletin* in the past. Your active involvement is greatly appreciated. With your help, we are beginning our 64th year in publication!

To better meet your needs, we have given *The Bulletin* a fresh new look for 1994. We have increased the size, reworked the format and selected a typestyle that is easier to read. We hope you like the changes!

We encourage everyone to get involved by submitting articles and photographs. And, as always, we welcome your suggestions and ideas.

Remember, *The Bulletin* is *your* publication. With your input, we will continue to grow and expand along with the changing needs of the medical community. Let us hear from you soon!

BULLETIN

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THOMAS S. BONIFACE, MD
Editor

Managing Editor ELEANOR PERSHING *Editorial Board* DENISE L. BOBOVNYIK, MD
CHRIS A. KNIGHT, MD L. KEVIN NASH, MD THOMAS S. BONIFACE, MD

The Bulletin is published six times a year by the Mahoning County Medical Society, 5104 Market Street, Youngstown, Ohio 44512. Phone (216) 788-4700.

The opinions and conclusions expressed herein do not necessarily represent the views of the editorial staff nor the official views of the Mahoning County Medical Society. Advertisements do not imply sponsorship or endorsement by the Mahoning County Medical Society of products or services advertised.

The Bulletin reserves the right to edit all contributions for clarity and length, as well as to reject any material submitted, including advertisements.

Subscription rate of $20.00 per year is included in MCMS dues. Correspondence and changes of address should be mailed to the above address.

President's Page

Medical Challenges for '94

I WISH TO THANK THE MEDICAL SOCIETY FOR THE HONOR OF BEING SELECTED TO SERVE AS PRESIDENT FOR 1994. THE CHALLENGES THAT face each and every one of us as a group as well as individuals are mounting, and it is your society's responsibility to be certain that you are prepared to address these issues. The council has been preparing for this challenge and has authorized an agenda that should provide education and awareness to all who participate.

The government has bundled all of the issues into a large generic package that has been labeled "Health Care Reform," but in fact this is only an attempt to popularize changes that have been occurring in our country for years. We remain one of the few areas where "managed care" has yet to capture a significant portion of health care delivery. But, as many of you know, this is rapidly changing as insurance companies and their customers strive to control costs. Their motives are very different however: employers and patients want to continue to receive the finest health care delivery at costs which can be predicted and more easily afforded; insurance companies want to "insure" that delivery, but to continue to experience high profits. The result is a concept that will ultimately cause rationing of care and control of the health care delivery system, with governmental restrictions applied.

Meanwhile, issues that organized medicine has identified as problematic continue to be ignored; tort reform, liability issues, and anti-trust relief are not high on the government's reform program.

My hope for this year is that your society will provide a stimulating atmosphere in which the entire organization can recognize the potential changes and respond in a proactive way that will benefit our patients and our members.

The agenda is ambitious: the legislative committee will remain active; community relations that have been developed over the past few years will be nurtured; symposiums and meetings to provide knowledge and to foster discussion will be sponsored; and the members will be asked to participate on committees that will be charged with developing new goals and visions for our group.

Again, I appreciate your confidence in selecting me as president and I hope that you will support our efforts to lead health care reform in the Mahoning Valley.

Chester A. Amedia, M.D., F.A.C.P.
President

From the Desk of the Editor

Evolution I

I HAVE ALWAYS BEEN FASCINATED BY THE CONCEPT OF EVOLUTION. IN SCHOOL WE ARE TAUGHT THE THEORY AS IT APPLIES TO THE animal kingdom, so we naturally associate the word primarily with living, biological entities. However, evolution occurs in many other ways, affecting anything that can be changed; but evolution is not simply the change itself. It is more a process which is a result of dynamic interplay of forces and, moreover, a process which is never static or predetermined or even predictable.

Classically, evolution occurs as a result of forces acting upon something, and consequently that something often becomes better — better in the sense that it is more efficient and more in keeping with those forces acting upon it. For instance, a species may change over millenia as a result of changes in climate.

Non-biological entities are also subject to evolution. Automobiles change in response to societal tastes, desires, and needs, as well as to technological advances. Less tangible things like organizations and societal systems evolve as well. In fact, they may even be seen as living things themselves in this sense. Yes, they are dependent upon human biological lives for their survival, but they are not necessarily in existence because of any purposeful, intentional design of biological man. Rather, they may become independent beings which evolve for reasons and forces beyond the comprehension of any one person or group of persons, and are, therefore, beyond purposeful control.

Thomas S. Boniface, M.D.

As you might expect, I consider our current health care system such an intangible yet very real being that has evolved over time. This system has not been constructed or designed by any one person or group of persons, and it does not exist for the sole purpose or benefit of any specified person or group of persons. Nor can this system be completely comprehended by any person or group, and therefore no person or group can possibly expect to purposely and predictably affect its evolution, despite what the sciolists in Washington and Columbus may have us believe.

This system has come about as a result of an extremely complex interaction of forces over many years. Certainly each of us can name a few of these forces: Medicare, organized labor's demands for benefits without cost, the rising sense of entitlement in the population (and in the medical profession), increased technology, increased rates of substance abuse and trauma, etc. To believe that one person, or even a task force, no matter how educated or well intentioned, can possibly design a system that will work better is tantamount to believing that one could build a better human being simply by altering its bodily functions. And yet, this is what is being proposed with the belief that someone, somewhere, somehow has this ability to fix that which has come about in response to so many forces over so many years.

Coming back to the principle of evolution — that natural forces cause natural change, which results in the improvement of the thing in question — an important corollary is that unnatural forces will result in unnatural changes, with resultant impairment of efficiency and function. Henry Ford II mandated the Edsel as his vision of the ultimate evolution of the automobile. Fortunately for the American public, there were other choices and the industry moved on. If we apply the same logic to

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TOD CHILDREN'S HOSPITAL

The leader in health care for our children...

Tod Children's Hospital is the only hospital dedicated exclusively to pediatrics in our region. Located in the center of our community, we offer an extensive array of consultation and subspecialty services to assist the primary care physician.

CLIP AND SAVE

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A Service of the Western Reserve Care System.

Society Installs Dr. Chester A. Amedia, Jr., as President

DR. CHESTER A. AMEDIA, JR., A NEPHROLOGIST, WAS RECENTLY INSTALLED AS PRESIDENT OF THE MAHONING COUNTY Medical Society at the Society's January meeting. Dr. Amedia currently serves as Chief of Nephrology for the Western Reserve Care System. He is also the medical director of the Kidney Center in Austintown, Ohio. He maintains an office at 1340 Belmont Avenue in Youngstown.

The 45 year-old physician is a Youngstown native who returned to practice his specialty after a nine-year career in the U.S. Army.

Dr. Amedia earned an undergraduate degree in zoology from Kenyon College in Gambier, Ohio, in 1970. He later graduated from the Ohio State University School of Medicine in 1973.

Prior to receiving his medical degree, he was commissioned as a second lieutenant in the U.S. Army Medical Corps. As a commissioned officer, Dr. Amedia completed a one-year internship and two-year residency at Tripler Army Medical Center in Honolulu, Hawaii. During his residency, he was also a clinical instructor at the University of Hawaii College of Medicine. In 1977, Dr. Amedia began a two-year Nephrology Fellowship at Walter Reed Army Medical Center in Washington, D.C.

In June 1980, he was licensed as a board-certified specialist in nephrology. By this time, Dr. Amedia had earned the rank of major, and in 1979, he was appointed chief of nephrology service at Landstuhl Army Medical Center in Europe. During his last two years in the army, Dr. Amedia served as nephrology consultant to the commanding general in the seventh medical command in Europe.

After receiving an honorable discharge in 1981, Dr. Amedia returned to northeast Ohio to practice. Since 1981, he has been an associate professor at NEOUCOM. He directed nephrology education at St. Elizabeth Hospital Medical Center for four years, before assuming the same function for Western Reserve Care System and Trumbull Memorial Hospital. As a researcher, he has studied the incidence of HIV in longterm hemodialysis patients and has participated in the investigation of the use of cyclosporine treatment for adult onset nephrotic syndrome.

Dr. Amedia is associated with nine hospitals in northeast Ohio and western Pennsylvania. Over the years, he has served on many hospital committees and medical review boards. He is on the executive committee of the Tri-State Renal Network, which includes Ohio, Indiana and Kentucky.

Dr. Amedia is active in many professional societies, including the International Society of Nephrology, the American Society of Apheresis, and the International Society for Artificial Organs. He is a member of the AMA, the OSMA, and the American Society of Nephrology. He is also a Fellow of the American College of Physicians.

Since his return to Youngstown, Dr. Amedia has been active promoting health awareness in his specialty. Since 1981, he has served on the Medical Advisory Board for the tri-county Kidney Foundation. He is a member of the American Kidney Foundation, and in the past, headed our Society's AIDS Awareness Committee and served on the research and program committees for the American Heart Association.

Dr. Amedia resides in Boardman with his wife Marilyn and their two children, Adrian and Christian. He brings a long list of accomplishments to his position as president of our Society. Our Society is fortunate to have such a disciplined and experienced leader at its helm.

Assistant to President for Minority Affairs and Affirmative Action is Named

THE NORTHEASTERN OHIO UNIVERSITIES COLLEGE OF MEDICINE (NEOUCOM) HAS NAMED KENNETH B. DURGANS, Ed.D., AS Assistant to the President for Minority Affairs and Affirmative Action. He will report directly to NEOUCOM President and Dean Robert Blacklow, M.D.

Durgans has over 10 years' experience in minority educational recruitment, including five years as the Director of Minority Student Affairs at The University of Notre Dame. He has also served as the Director of Multicultural Services at Olivet College in Olivet, Michigan. Most recently, he has been Olivet's Interim Vice President and Dean of Student Services.

In his new position, Durgans will work closely with NEOUCOM's three consortium universities — The University of Akron, Kent State University, and Youngstown State University — in an effort to attract qualified students to the college's B.S./M.D. program.

He will also work with administrators and faculty at NEOUCOM to develop and implement policies and programs for recruiting and retaining minority students, faculty and staff. Dr. Blacklow stressed the importance of graduating minority physicians, saying it is "essential if we are to increase our commitment to cultural diversity in health care."

Kenneth B. Durgans, Ed.D.

Durgans received his doctor of education degree from Western Michigan University and masters' degrees from the University of Dayton and Kent State University.

Throughout his career, he has developed and implemented programs for supporting the academic and cultural concerns of minority students. He has also developed programs for enhancing awareness and appreciation of cultural diversity.

Officers Installed at MCMS January Meeting

NEW OFFICERS AND MEMBERS OF COUNCIL WERE INSTALLED AT THE SOCIETY MEETING HELD TUESDAY, JANUARY 18, 1994 AT THE Youngstown Club. The meeting was conducted by retiring President Dr. Eric Svenson. Dr. Svenson made special mention of Janssen Pharmaceutica for their product display, presented by sales representatives Joe Shellem and Bill Chisholm.

The membership stood for a moment of silence, to remember those members who had passed away during the year: Drs. Herman L. Allen, Armin V. Banez, John G. Guju, Frederick M. Lamprich, and Rollis R. Miller.

The Society acknowledged its past presidents who were in attendance. They were: Drs. Rashid Abdu, James Anderson, Robert Barton, Jane Butterworth, Andrew Detesco, George Dietz, Robert Jenkins, Jack Schreiber, Hai-Shiuh Wang, and Karl Wieneke.

The membership also recognized Mrs. Mary Ann Anderson and Mrs. Dolly Handel, past presidents of the Alliance, who were in attendance.

For their contributions to The Bulletin in 1993, Dr. Svenson acknowledged the following people: Editor Dr. Kevin Nash, Dr. Robert Fisher, Dr. Anand Garg, Dr. Dan Handel, Mrs. Jeannine Lambert, and Dr. Robert and Mrs. Mary Jane Jenkins. Dr. Svenson also expressed his appreciation to outgoing members of Council Dr. Prabhudas Lakhani, Alternate Delegate, and Dr. Alam Quadri, Council Member-at-Large.

Dr. Jack Schreiber, a past President, installed the following members:

Officers:

President ..... Dr. C. Amedia
President-Elect ..... Dr. D. Handel
Secretary ..... Dr. D. Goldsmith
Treasurer ..... Dr. N. German

OSMA Delegates:

Dr. J. Anderson
Dr. D. Bobovnyik
Dr. D. Handel
Dr. L. Slusher
Dr. H. Wang
Dr. K. Wieneke

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(L to R) Bill Chisholm and Joe Shellem, Janssen Pharmaceutica representatives.

▲ *(L to R) Dr. Chet Amedia and Dr. Eric Svenson*

Alliance President-Elect Mrs. Mary Walton

(Standing L to R) A. Mehle, K. Wieneke, N. German, R. Gentile, D. Goldsmith, C. Knight, R. Abdu, J. Anderson. (Seated) E. Svenson, C. Amedia, D. Handel

1994 License Renewal To Begin In March

by Anand G. Garg, M.D. and Lauren Lubow, J.D.

RENEWAL APPLICATIONS FOR THE UPCOMING BIENNIUM WILL BE MAILED IN EARLY MARCH TO THE ADDRESS OF RECORD OF each physician holding a current Ohio medical, osteopathic or podiatric license. Please check the address label affixed to the envelope in which this newsletter was mailed and notify the Medical Board in writing of any changes no later than March 1, 1994.

Physicians who have not received a renewal application form by the last week of March should contact the Medical Board's Records Department at 614/466-3934.

The renewal fee for the upcoming biennium has been increased to $250. Twenty dollars of this fee has been earmarked for the new Ohio Physician Loan Repayment Program being administered by the Ohio Department of Health. Checks should be made payable to the Treasurer, State of Ohio and should be sent along with the completed renewal application form directly to the State Treasurer's Office. Enclosing correspondence or anything else with your check and completed application form results in rerouting of your materials to the State Medical Board offices, which will cause a delay in processing your application. Failure to 1) submit the appropriate fee, 2) answer all of the questions on the application, or 3) sign the application form or your check will also delay processing.

Completed renewal applications must be received no later than July 1, 1994. A late penalty fee of $25 will be assessed for applications sent after that time. Failure to submit an appropriately completed renewal application by September 30, 1994 will result in the automatic suspension of your license effective on October 1, 1994. If you do make a good faith effort to renew by submitting the required fee and completed application, Ohio law protects you by permitting your continued practice, even if a wallet identification card confirming your renewal has not yet been issued.

Wonder why your coworker got his wallet card before you did, when you sent your applications at the same time? The State Treasurer's Office handles incoming applications in batches, and sometimes they get separated during processing. Applications can also get separated if questions were left unanswered or signatures were forgotten.

Normal processing time for renewal applications is six to eight weeks, so please refrain from calling the Medical Board's offices to check on your application until that time has elapsed. The two members of the Medical Board's staff who handle license renewal receive an average of 320 calls a day; premature telephone inquiries may interfere with expedient processing.

A final reminder: Ohio law specifies that you must have completed 100 hours of Continuing Medical Education (at least 40 hours in Category I) no later than July 1, 1994.

RENEWAL CALENDAR

3/1/94
ADDRESS CHANGE DEADLINE

7/1/94
CME DEADLINE

7/1/94
RENEWAL APPICATIONS DUE

9/30/94
CURRENT LICENSE EXPIRES

OSHA Bloodborne Pathogens Standard Update

John L. Dunne, D.O. Occupational Medicine
William Johnson, Johnson & Gunn, OSHA consultants

In the months following the last Bloodborne Pathogens seminar, sponsored by the Mahoning County Medical Society, we have had many questions and comments from members of the medical community on complying with the standard. Many times, in the search for an answer or interpretation, we had occasion to speak to OSHA officials and what follows is a compilation of many of the responses from OSHA that may be of interest to the medical community.

The statements attributed to OSHA reflect current interpretation of the standard and are primarily drawn from official letters of interpretation as well as internal OSHA memoranda. It is important to realize that OSHA tends to write performance-based standards, stating the objective to be achieved but not specifically how to achieve it. The Bloodborne Pathogen standard is written this way; i.e. employees must be protected and the employer must utilize his own judgement in complying.

Do exam gloves used for rectal examinations need to be red bagged?

No. (JD). It would be prudent. (WJ)

This question can be extended to include any examination of mucous membranes where the standard requires the use of gloves. If not contaminated with visible blood then "red bagging" is not required. However, the performance-based standard implies that the employer must determine where possible exposure to blood or "other potentially infectious material" (OPIM) may occur. So, if one were to compact a waste container of such gloves, can there be a potential release? One inspector stated that she would issue a citation if she witnessed a physician discarding an exam glove into the regular trash can. The physician would have to seek redress through the appeal process.

(FYI: While it is sound public health policy to do so, OSHA does not have a requirement that gloves be changed between patients.)

Must bandaids and bandages be red bagged?

It depends. (JD & WJ)

The answer is based on the *potential for release of blood or OPIM*. The standard defines regulated waste as liquid blood or OPIM or semi-liquid blood or OPIM; contaminated items that would release blood or OPIM in a liquid or semi-liquid state if compressed; items that are caked with dried blood or OPIM and are capable of releasing these materials during handling, etc. Bandages which are not saturated to the point of releasing blood or OPIM, if compressed or handled, would not be considered regulated waste and need not be "red bagged." Certainly most bandaids fall into the nonregulated category but OSHA emphasizes that the employer is responsible for making the determination of the existence of any regulated waste.

Is hand washing always required when changing gloves?

Yes, if the gloves are used as personal protective equipment. (JD & WJ)

In response to a request that this requirement be waived when phlebotomists remove gloves between patients, when there is no visible contamination of the gloves with blood, etc., OSHA responded that section (d)(2)(v) of the standard specifically requires handwashing after removal of gloves or other personal protective equipment. OSHA believes the benefits of this practice far outweigh the concerns of excessive hand washing and delays in performing procedures.

Are gloves required for routine injections?

No, not as long as contact with blood or OPIM is not anticipated.

However, if there is typically a drop of blood present, which the employee would dab with a swab, then that would be a covered procedure. A better idea would be to have the patient hold pressure with a swab.

Saliva

In general, the standard does not classify saliva as a body fluid that is covered by the standard. There are two exceptions to this (1) if the saliva is visibly contaminated with blood and (2) saliva in dental procedures.

Feminine Hygiene Products

OSHA does not consider discarded feminine hygiene products to fall within the definition of regulated waste. OSHA expects the waste containers into which these products are discarded to be lined in such a way as to protect employees from contact. The employer's general responsibility still stands, however.

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OSHA Bloodborne Pathogens Update

(cont. from pg. 16)

Must throat swabs be red bagged?

No. See saliva above.

Question concerning soiled linens.

An employee who handles linens soiled with feces, nasal secretions, sputum, sweat, tears, urine, vomitus or saliva from other than a dental procedure, that are not contaminated with visible blood, would not be occupationally exposed during that task, as these substances are not "other potentially infectious materials" (OPIM). However, if the linens were soiled with urine that contained visible blood or would reasonably be anticipated, due to a medical condition that would lead to hematuria, the employee would be occupationally exposed. A non-designated employee should then defer all tasks involving linen soiled with visible blood to employees designated to perform tasks involving blood exposure.

Sharps — a few comments.

The overwhelming majority of exposures continue to come from needle sticks and many occur during recapping. OSHA states that the standard *prohibits* recapping of needles unless no alternative is feasible or recapping is required by a specific medical procedure. When recapping *must* be performed, it must be performed with a mechanical device or a one-handed technique. You *may not* use a one-handed scoop, recapping device, hemostat, etc. for recapping unless the recapping itself is absolutely necessary. This would also include needles used for injection of allergens. There are no "OSHA APPROVED" devices; OSHA does not typically review products.

Legislative Update

Health Care Reform Issues

"GRASS ROOTS EFFORTS" IS THE CURRENT MESSAGE BEING DELIVERED TO INDIVIDUAL PHYSICIANS BY ORGANIZED MEDICINE regarding actions to be taken in discussing health care reform efforts with their state and national legislators.

At the recent National Leadership Conference sponsored by the AMA and held in San Francisco, February 11-13, P.O.W.E.R was launched. This acronym stands for "Physicians Organized to Work for Effective Reform." The message to be delivered is that no American should ever go without health care coverage; that all Americans should be able to choose their physicians; that medical decision-making be reserved for patients and physicians, not third-party administrators; that the health care costs be constrained by competitive forces and major professional liability reforms, not by strict global budgets or spending caps; and, finally, that all Americans continue to receive high quality health care.

We are asked by our AMA to get involved and stay involved and help to advance meaningful reform legislation in 1994 which meets with medicine's objectives and those of the patients we serve. For physicians to be empowered in the negotiating process, anti-trust relief is required. Such relief may be on the way, but only through our individual and collective efforts.

Senators Orin Hatch (R-UT) and Strom Thurmond (R-SC) have introduced S1658, while representative Bill Archer has introduced HR3486. These resolutions, with the backing of the AMA, are referred to as the Health Care Anti-Trust Improvements Act of 1993. These bills represent an initiative toward ensuring that patients and physicians, rather than insurance companies and actuaries, control patient care in any reformed health care delivery system.

The next step to be taken is to make contact with Congressman Jim Traficant and Senator John Glenn to ask for their support of this anti-trust relief initiative. When the opportunity arises, make sure that you take the time to discuss reform issues with patients. The AMA brochure "A Message to my Patients," which describes medicine's reform priorities, can be placed in your waiting room.

If you have stories of how a patient's access to medical services may have been restricted or denied, pass them on to AMA headquarters. You should also know that State Senator Joseph Vukovich has also requested that physicians send him examples of such problems, so that he may address these on the State Senate Floor.

Physicians are encouraged to continue providing care without charge or at reduced rates for the uninsured and those who cannot afford care. The AMA will also hold a Health Care Reform Summit in Washington, D.C. on March 8, 1994.

The local Medical Society Legislative Committee recently met with State Representatives Robert Hagan and Ronald Gerberry and Senator Joseph Vukovich. I believe that a good rapport was established with our state legislators, and a frank discussion regarding health care reform issues and the political process

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Daniel W. Handel, M.D.

Daniel W Handel, MD

I·N M·E·M·O·R·I·A·M

ARMIN V. BANEZ, M.D.

JUNE 30, 1925 —
JANUARY 16, 1994

From the Editor

(cont. from pg. 6)

our health care system, we are being asked to go along with one concept or design i.e. managed care, with universal coverage, mandated premiums, benefits, and deliverance of care, to the exclusion of many of the concepts currently in place, simply because they do not work for everyone. I am sure there were a few Edsel owners who were happy, just as I am equally sure there are those of us who do not wish to own a Lexus.

I would respectfully conclude that there is no one system or design of health care deliverance that will solve even a plurality of the problems we currently face. The vast majority of people will give up that which has evolved because of them and their needs and have in its place a compromise of unimaginable proportion that will likely serve no one very well. Diversity and flexibility have always distinguished our nation from others and they have helped to make our country the land of opportunity and individual freedom. We should cherish these characteristics and encourage their inclusion into the reform process.

Legislative Update

(cont. from pg. 18)

took place. Our legislators agreed that no meaningful health care reform legislation would take place in the state of Ohio before January of 1995.

The legislative committee will continue to meet with our legislators on a regular basis. The message that has been repeatedly stated by our legislators is that physicians are not heard from when issues related to health care are addressed. We need to make our presence and concerns known to our legislators. The optometrists, chiropractors, nurses, and physician's assistants have had a more visible profile with their legislators and have enjoyed success in recent health care initiatives.

Please take the time to get to know your legislators. I believe we share common concerns with them and I believe we can arrive at mutually agreeable solutions to health care reform.

How a Congressional Bill Becomes Law

Byzantine. Bizorre. Rube Goldberg. A nightmore. Those ore just o few of the words thot hove been used to describe the congressionol process by which legislotion — such os President Clinton's health system reform meosure — becomes the law of the land in America. Yet, puzzling os our system may oppear to loymen, the legislotive process has deep roots that extend ocross the centuries ond borrow from English parliomentory rules, Greek ond Romon traditions ond Hebrew tribol procedures.

Today's legislotive procedure is derived from the orchitecture of our government, as drawn up in the Constitution. The framers created a bi-cameral legislature: The House of Representotives, in which Members are elected to two-year terms by direct populor vote, represents the citizens of the nation. And, while Senators hove also been elected by direct citizen vote since 1912, their originol mission wos to represent their individual states os o whole. For that reoson, individuol Senotors used to be elected by o majority vote within their stote legislotures. Senotors serve six-year terms and are given special powers, such as the power to opprove or disapprove treaties with foreign nations; it's for that reason that today's NAFTA debate took place mainly in the Senate. Bills that raise revenue or provide for the federol budget originote in the House of Representatives ond it's for that reason thot the House Woys and Means Committee is considered one of the most powerful committees in Congress.

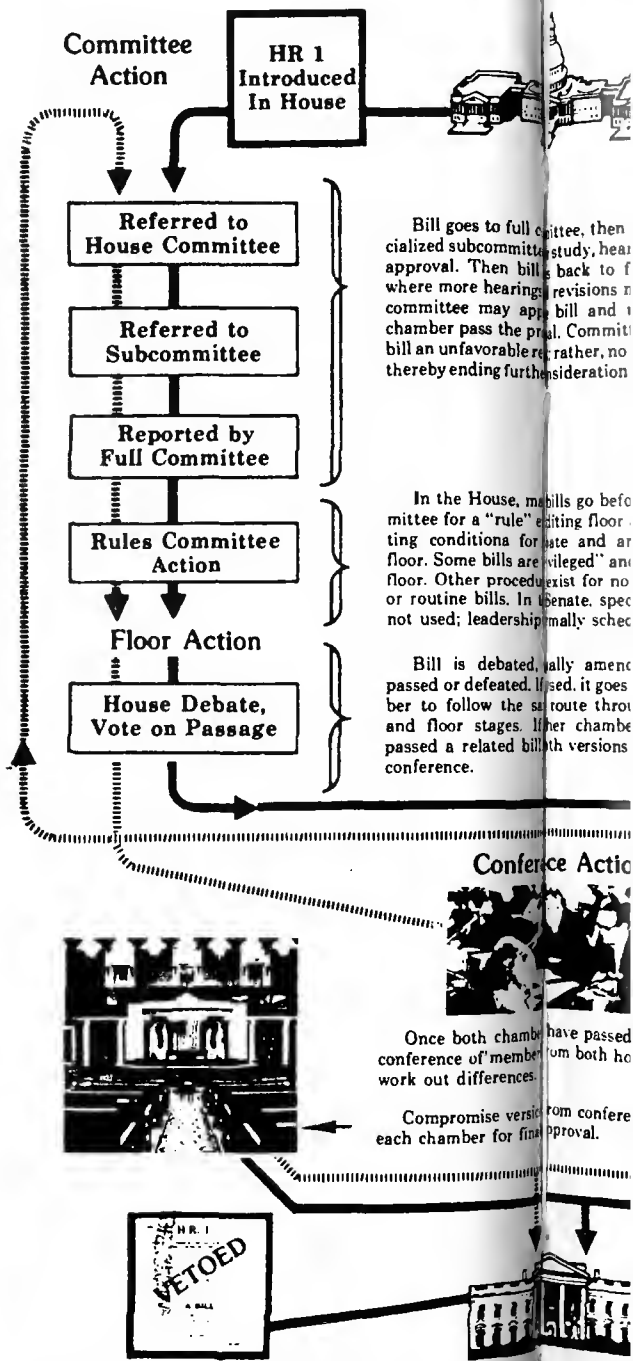
Although the Constitution sets out those general rules and others, the specific rules for the introduction of o bill and its future possoge have been drawn up by each individual chamber. The chort at left demonstrates the most typical way o bill would become law; however, changes in or suspension of the Senate and House rules are not uncommon, especially in times of emergency.

Perhaps the most fomous depiction of the bi-camerol legislotive process was given to us by Thomos Jefferson, who described the system as similar to drinking hot tea from a cup and soucer. Just as pouring tea from the hot cup into the cool saucer tends to moke the beverage more drinkable, hosty or passionote meosures introduced os bills into the House could be reviewed more reflectively from the Senate, where six-year terms help put distance between Senote oction and voter retaliotion.

In addition to the involvement of both the House and the Senote, the Executive branch also participates in the legislative process. The President may propose specific legislotion, os Bill Clinton has done with health system reform, and see his legislotion reviewed and debated in both houses. In addition, the President olso has the weapon of the veto to block legislation which he may oppose. Should the President veto o bill after it has passed both chambers, Congress can attempt to override thot veto by mustering o two-thirds vote.

In short, the entire system has been created to assure a thorough review of each measure; to protect the needs of the people os well as the individual states; and to protect the prerogatives af the President as the Executive. Further, the time required to go through oll of the normal steps also provides voters and citizens to participate in the debate via phone calls, letters, faxes and public appeals to the legislators.

Thia graphic ahowa the most typical way in which proposed legi
tion is enacted into law. There are more complicated, as well as simp
routes, and most bills never become law. The process is illustrated w
two hypothetical bills, House bill No. 1 (HR 1) and Senate bill No



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Bill is debated, ally amend
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and floor stages. If her chambe
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Once both chamb have passed
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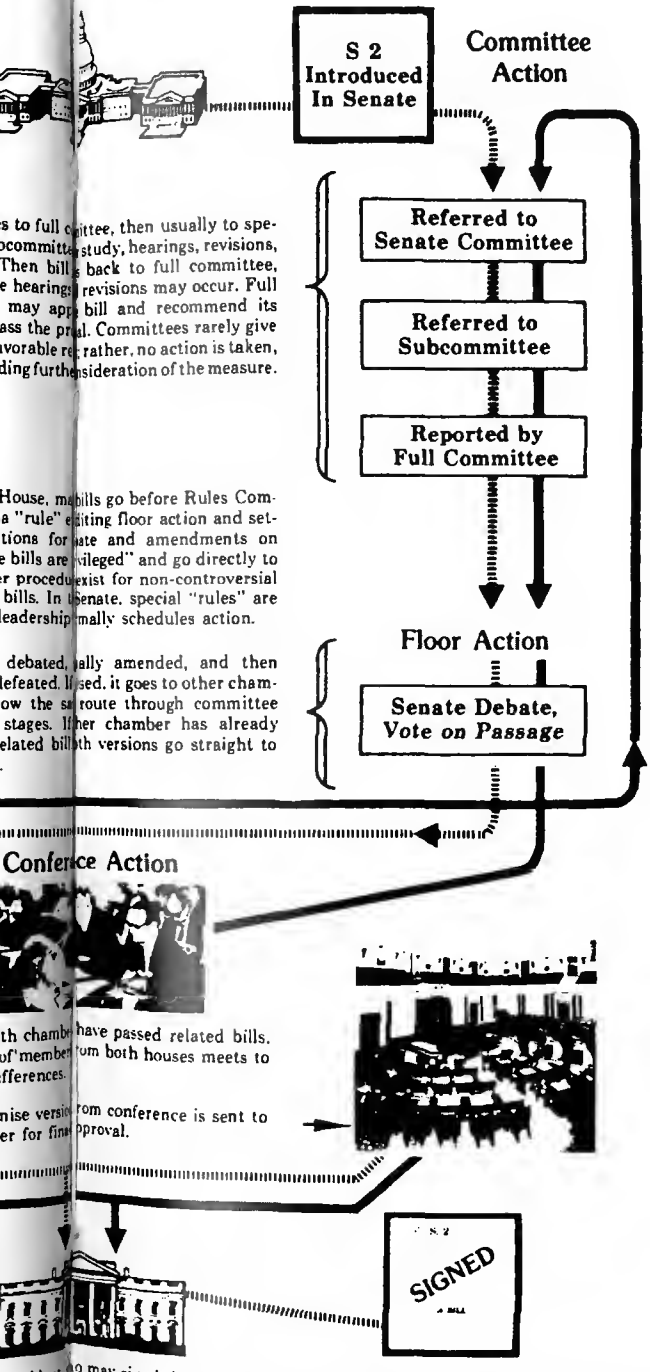
work out differences.

Compromise versi rom confere
each chamber for fina pproval.

Compromise bill approved by both houses is sent to the president. o may sign i
and return it to Congress. Congress may override vetn hy two-thirds rity vote in

(S 2). Bills must be passed by both houses in identical form before they can be sent to the president. The path of HR 1 is traced by a solid line, that of S 2 by a broken line. In practice, most bills begin as similar proposals in both houses.



RIDER

A provision added to a bill that may not have anything to do with the original bill's purpose. Riders are usually attached to legislation for one of two reasons. Opposing legislators may wish to include a provision that is so objectionable, the entire measure is vetoed by Congress or vetoed by the President. In addition, a rider that contains special provisions (such as pork-barrel legislation) may be affixed in the hope that it will be approved when the entire bill is approved by Congress and signed by the President.

EUNUCH RULE

In the era of term limits, the "eunuch rule" has made a reappearance. Many state governors have been forbidden to run for more than one or two terms. Now, in 15 states, term limit laws also apply to federal and state legislators as well. This legally rendered "political impotence" is often referred to as the "eunuch rule."

POCKET VETO

The President must decide to sign or veto a bill within ten days after it has been approved by both houses of Congress. If a bill is passed within 10 days of the adjournment of Congress, the President can wipe out the bill by simply not signing it, i.e, "placing it in his pocket". This silent veto cannot be overturned by a two-thirds majority of Congress, since that Congress has adjourned.

DISCHARGE PETITION

Many Members of Congress sponsor bills in the House that never see the light of day; rather than go through the traditional step-by-step procedure, they remain tabled in committee. The only way a Member of Congress could demand a floor vote to a bottled-up bill was to request a discharge petition. If a majority of the Members of Congress (218) signed the discharge petition, the bill could be released.

However, until September, the names of those Members of Congress who actually signed a discharge petition remained secret. Such secrecy permitted a representative to claim he favored the measure when, in actuality, he had not supported the discharge. For that reason, bills such as those sponsoring a balanced budget amendment, term limits and other congressional reforms have not been subjected to a vote. Now, however, Congress has abandoned the secrecy behind discharge petitions. A national publicity campaign in support of Congressman Jim Inhofe (R-Oklahoma) forced the House to relent. As a result, chances are good that many measures that have been tabled for years may now win the right to a floor vote in the House.

Courtesy of American Medical Association
Participation '94 Magazine

Your Licensing Fee and the State Medical Board

by Anand Garg M.D. and Lauren Lubow, J.D.

After 20 plus years of ongoing attempts by the Medical Board and professional associations alike to insulate the Medical Board from the vagaries of Ohio's General Revenue Fund, potentially crippling cuts to the Medical Board's budget in late 1992 unexpectedly became the catalyst for creation of a special revenue fund for Ohio's regulatory boards. The change means not only that nearly all (90%) of the revenues generated through the Medical Board's licensing and renewal fees will now come directly to the Medical Board to support its own operations, but also that those revenues generated by the Medical Board will be less likely to face the significant budget cuts frequently imposed upon the State's General Revenue Fund.

In late 1992, substantial General Revenue Fund cuts threatened the Medical Board with the layoff of 25% of its staff. With a major layoff, the Medical Board feared reduction or even elimination of many services. The challenges created by such fiscal uncertainty were compounded as the Medical Board's workload continued to increase; in the preceding biennium, requests for written licensure verification had increased from about 26,000 in 1990 to 43,000 in 1992; the number of complaints lodged against licensees had increased by 12%, from 1654 in 1990 to 1852 in 1992; mandatory reports involving licensees had grown by 38%, from 604 in 1990 to 833 in 1992; and the number of doctors subject to probationary monitoring had mushroomed by 99%, from 72 in 1990 to 143 in 1992. In addition, the Medical Board's duties had been expanded by legislation to include responsibility for examination and licensure of electrologists as cosmetic therapists, issuance of special activity certificates and visiting faculty certificates, surveillance and approval of treatment providers for impaired pracitioners, and evaluation of some licensure applicants' ability to verbally communicate in English.

In response, the Voinovich Administration promoted, and key legislators from both political parties implemented, a special "rotary" fund to ensure that state regulatory boards would not risk continual exposure to future budget-trimming measures. Through the years, license and renewal fees had been deposited into the General Revenue Fund, with only a portion — for many years, about 60% — set aside to fund Medical Board operations. The new special fund is expected to be an effective and efficient solution. Although the new single rotary supports the operations of more than 20 state regulatory boards, spending limits imposed on each agency based directly upon the revenues each generates prevent any one agency from utilizing more than its fair share of the fund.

Fees the Medical Board generates can finally be used for its own operations, rather than going to support other unrelated programs through the State's General Revenue Fund. The increase in available funds will mean not only better services for Ohio's citizens, but also better and faster services for the benefit of the profession. We hope you will applaud this reform as we do.

When renewal applications are delivered in early March, few physicians will fail to notice the increase in this biennial renewal fee. Several factors account for the rise.

At the outset, physicians need to know that $20 of the new $250 renewal fee goes directly to the Ohio Department of Health to administer the new Ohio Physician Loan Repayment Program created by House Bill 478. Of all monies ultimately allocated for Medical Board operations during FY94-95, about 87% is designated to support existing services and a new mandate imposed by the General Assembly to monitor clinical laboratory ownership and self-referrals. Remaining funds (13%) will be used to develop programs dealing with early intervention in substandard practice, prescription drug diversion, information access, computer equipment and management support.

Licensees may find it interesting to learn that the upcoming $230 renewal fee is only slightly higher than the 1992 national average of $212. The comparable 1992 fees range from $900 in Connecticut to $40 in Guam and New Mexico.

New programs supported by Ohio's renewal fee increase address the need — identified by both the Medical Board and the licensed professions — to better handle the Medical Board's enforcement obligations. The Medical Board's budget thus includes:

- **A pilot early intervention project.** Selected cases involving allegations of substandard medical care will be reviewed by an expert panel to assess those practice problems which may warrant educational or restrictive action, but not necessarily formal disciplinary action. At the present time, the Medical Board ordinarily has only two options for dealing with such allegations following investigation, subpoena

continued on pg. 23

Licensing Fee and State Medical Board *(cont. from pg. 22)*

of patient records, and review of those records by a physician expert. The Medical Board may pursue formal disciplinary action through an administrative hearing or close the complaint without formal intervention. Option one has not always proven to be the best answer, since administrative hearings are costly, lengthy and tend to focus not only on the central medical issues involved, but on the legal aspects of a case as well. Option two, on the other hand, may allow a potentially correctable problem to go unaddressed until it develops into a more serious problem requiring formal action. The early intervention project will concentrate on correcting substandard practices before license suspension or revocation is the only recourse.

- A prescription drug unit to permit focused investigation and action in cases involving massive overprescribing or misprescribing of prescription drugs by physicians. The unit plans to coordinate with other agencies such as the U.S. Drug Enforcement Administration and the Ohio Board of Pharmacy to avoid duplication of their efforts. The Medical Board's primary focus is on dangerous prescribing practices by physicians, rather than on criminal activity involving intentional diversion of prescription medications as "street drugs." Much misprescribing, while not of the scope and nature to form the basis for a criminal prosecution, still demands intervention to prevent drug misuse and to protect innocent patients.
- Improved access to information through additional Medical Board publications, an additional records staff position, toll-free 800 number access, and on-line computer services that permit access to public information by large volume users. In 1993, the Medical Board provided over 52,000 license verifications through its two-person records unit, received over 2,000 new complaints and responded to over 3,800 initial licensure requests.

Perhaps the single major program envisioned by the Medical Board that remains unsupported by the current renewal fee relates to development of a research and educational arm of the Medical Board to devise informational programs and publications. Materials and presentations would focus on licensees' legal and ethical obligations and health care consumer education. The expectation is that such a program would reduce complaints and prevent practices that might otherwise result in more formal Medical Board intervention. The fact that, time after time, the Medical Board hears from practitioners under investigation that they simply didn't know what was expected of them under the law is illustrative of the continuing need for such programs. The Medical Board also sees a need for development of competency assessment and focused continuing medical education in instances where other information leads the Medical Board to believe a problem exists. Although the Medical Board has explored this possibility with various professional groups and educators, funding remains a limiting factor.

As always, the Medical Board is eager to hear from you about concerns you may have or improvements you would like to see. Letters can be addressed to the Board's Executive Director, Ray Q. Bumgarner, at 77 South High Street, 17th Floor, Columbus, Ohio 43215-0315. The Board's Public Inquiries Officer, Ms. Joan Wehrle, is also available by phone at 614/466-3934. Your comments are enlightening and appreciated.

Of course, I am always available for any service I can provide as your representative on the State Medical Board.

Medical Board staff members Thomas Dilling, J.D., William Schmidt J.D., and Diann Thompson, J.D., also contributed to this article.

Officers Installed at MCMS January Meeting *(cont. from pg. 14)*

OSMA Alternate Delegates:

Dr. J. Butterworth	Dr. C. Kohli
Dr. A. Garg	Dr. R. Marina
Dr. C. Knight	Dr. L. Nash

Members-at-Large:

Dr. T. Albani	Dr. J. Resch
Dr. T. Boniface	Dr. M. Smith
Dr. J. Lloyd	Dr. W. Sutherland
Dr. A. Mehle	Dr. T. Traikoff
Dr. N. Proia	Dr. L. Yakubov
Dr. B. Ravi	Dr. E. Young

Editor of Bulletin:
Dr. T. Boniface

Public Relations Chairperson:
Dr. R. Gentile

Foundation Trustees:

Dr. R. Abdu	Dr. P. Lakhani
Dr. N. German	Dr. B. Lim
Dr. S. Kalavsky	Dr. C. White

Following the installation, Dr. Svenson presented the president's gavel, made by Dr. James Anderson, to new President Dr. Chester Amedia. Dr. Amedia then presented the president's plaque and pin to Dr. Svenson.

After these presentations, Dr. Svenson acknowledged the support and cooperation of various groups and organizations, including: Council and the Society, the Lake to River Health Care Coalition, the Bar Association, and the Media.

Dr. Svenson also announced that the current membership stands at 374 active members, 94 emeritus, 61 resident, and 18 non-resident members.

New President Dr. Amedia introduced Mrs. Mary Walton, the President-Elect of the Alliance. Mrs. Walton commented on events scheduled for the Alliance in 1994.

The membership voted to change the date of the March Society meeting from Tuesday, March 15, to Thursday, March 27. The March 27th meeting, a joint Society and Alliance dinner meeting, will be held at Antone's Banquet Centre.

Mahoning County Board of Health Opens Tuberculosis Clinic

THE RISING RATE OF TUBERCULOSIS AND THE EMERGENCE of multiple drug-resistant strains have forced us here in Mahoning County to review our tuberculosis control measures. National and state goals are aimed at the elimination of tuberculosis by the year 2010. We must, therefore, decrease tuberculosis control rates to one case per one million persons. In order for us to achieve these goals, Mahoning County must significantly expand screening and detection of TB infection.

The new Mahoning County Board of Health Tuberculosis Clinic was created to coordinate screening, preventive therapy and treatment of active tuberculosis. Our facility can perform skin testing, chest radiographs, sputum analysis and any necessary blood work. All patients placed on preventive therapy are monitored monthly. Treatment protocols for active disease are tailored to the patient needs and follow the current Center for Disease Control standards. All therapy will be directly observed.

Patients considered high risk for developing tuberculosis, who should be screened yearly, include the following:

1. Persons with HIV infection.
2. Close contacts of known infectious tuberculosis cases.
3. Persons with other medical risk factors known to substantially increase the risk of tuberculosis once infection has occurred.
4. Foreign-born persons from high-prevalence countries (Asia, Africa and Latin America).
5. Medically underserved low-income populations, including high-risk minorities.
6. Alcoholics and intravenous drug users.
7. Residents and staff of long-term care facilities, such as correctional institutions and nursing homes.
8. Persons in settings where disease would pose a hazard to a large number of susceptible people, such as newborn nurseries, health care facilities and shelters for the homeless, etc.

The standard means of testing is the Mantoux Test using 5 TU (Tuberculin Units) of PPD (Purified Protein Derivative) injected intradermally. The site should be evaluated 48 to 72 hours after the test has been applied. Any area of induration, not redness, should be measured transversely across the arm and recorded in millimeters (mm).

Candidates for preventive therapy, regardless of age, if not previously treated, should include the following:

A reaction of 5 (five) mm or more is POSITIVE in the following groups:

1. Persons who have had close recent contact with a patient with infectious tuberculosis.
2. Persons who have chest radiographs with fibrotic lesions likely to represent old healed tuberculosis.
3. Persons with HIV infection.

A reaction of 10 (ten) mm or more is POSITIVE in the following groups:

1. Persons with other medical risk factors known to substantially increase the risk of tuberculosis once infection has occurred.
2. Foreign-born persons from high-prevalence countries.
3. Medically underserved low-income populations, including high-risk minorities.
4. Alcoholics and intravenous drug users.
5. Residents and staff of long-term care facilities, such as correctional institutions and nursing homes.
6. Persons in settings where disease would pose a hazard to a large number of susceptible people, such as newborn nurseries, health care facilities and shelters for the homeless, etc.

All persons under 35 years of age with a 10 mm or greater increase in a two-year period or patients 35 and older with a 15 mm increase in a two-year period are considered skin test converters and candidates for preventive therapy. A reaction of 15 mm or more is classified as POSITIVE in all other persons. Preventive therapy should be offered to everyone under the age of 35. No patient should begin on preventive therapy until active disease is excluded.

Prevention and treatment must be uniform throughout the County in order to achieve our goal of TB elimination, prevention and treatment must be uniform throughout the County. We encourage you to refer all patients requiring prophylaxis or therapy for active disease. The tax-supported TB clinic is able to provide care to all referrals, regardless of insurance status. Please feel free to take advantage of our services or to contact us with any questions regarding tuberculosis.

—Robert DeMarco, M.D., F.C.C.P.

On The Cover

"Dancer"

Larry Fodor
Original Mixed Media
42" x 49"

AN AREA OFTEN NEGLECTED IN THE STUDIES OF CONTEMPORARY ART IS ART OUTSIDE THE ENVIRONS OF NEW YORK. This is particularly true for western art and Southwest artists. There have been art movements in California, Santa Fe, Taos, and Washington that began in the late 1800s and throughout the 1900s that sadly have been overlooked. Fortunately, there are many excellent art magazines available that bring contemporary western art to the public's attention. However, one needs to know what to look for and where to look. I do wish Youngstown had bookstores to match those of Columbus!

This month's featured artist is one of those Southwest artists who brings a contemporary look to an old subject, the Native American Indian. Born in 1951 in Los Angeles, California, Larry Fodor became intrigued and concerned with the cultures of the Southwest after numerous visits with his family to the area during his teen years. For years he collected books and researched information on Native American cultures. After graduating from high school, Fodor received an Associate Degree in Fine Arts from Orange Coast College, a Bachelor of Fine Arts from Otis Art Institute. One year later, he completed graduate work in lithography.

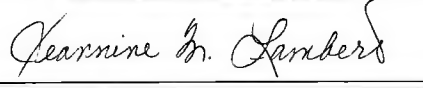
Following his studies, Fodor traveled and studied in England, France, Germany, Holland, Italy and Switzerland, an itinerary he has repeated several times over the years. He also lived, traveled and studied for eight months in Kathmandu, Nepal before coming back to California to study lithography independently and complete further studies in drawing and design at Orange Coast College. After these years of studies and working as a printer for a publisher of hand-pulled limited edition graphics in Los Angeles, he established his own hand lithography workshop in Santa Barbara, this time focusing mostly on his own works.

Fodor moved his studio and print shop to Tucson, Arizona for several years to be closer to the Southwest and desert environments. He made frequent visits to archaeological sites and Native American lands to get a better understanding of what lies at the root of the American Indian culture. These visits have continued throughout the years, even after Fodor moved back to Santa Barbara, California. He has since produced several series of lithographs while developing a series of mixed media paintings and large mixed media paintings similar to "Dancer" on the cover. He spends approximately half the year devoted to painting and the other half to his print making.

In "Dancer", there are several things Fodor has done to bring such a dynamic image to the viewer. The canvas is electric with motion and intensity. While filling the canvas, the costume is only semi-important compared to the emotion felt from the overall image. Part of the wands or spears reach out beyond the canvas, and feathery movements of charged energy dance across the canvas everywhere. The image is almost ethereal and very spiritual,

continued on pg. 27

Jeannine M. Lambert



On The Cover *(cont. from pg. 26)*

nothing like the somber stare created by the old masters of Western art. To Fodor, mixed media includes oils, watercolors, acrylics, chalks, inks, and colored pencils. It is as if one medium could not bring the truth to the canvas. As Fodor said, "Integrating and at once transcending the physical, theatrical, and the narrative, my images speak of the emotional, the intuitive and the intellectual process". Fodor feels his responsibility is to "become the bridge between the physical and the non-physical."

In recent years, Fodor has studied with the artist Embroli and his canvases have begun to change into large abstracts exploding with color and emotion. I call them "spiritual abstracts", because they do stir the emotions more powerfully than the literal image of the American Indian. These spiritual abstracts still carry Native American imagery in them. They, too, are quite beautiful. So you see, there is more in this world than New York art.

Larry Fodor has appeared in numerous selected shows and exhibitions throughout the United States since 1973, with paintings in many private and corporate collections here and abroad.

Ohio State Medical Association Offers Medical Law Guide

The Ohio State Medical Association has produced the 1993-94 "Physicians' Guide to Ohio Law." This guide contains the most comprehensive and up-to-date information available about Ohio's laws as they pertain to medical practice.

Members of the Ohio State Medical Association can request one free copy of the "Physicians' Guide to Ohio Law." Nonmembers can receive the guide at a cost of $50 per copy, plus $2.88 tax. Members who wish to receive additional copies will also be charged $50 per copy plus $2.88 tax.

For more information, contact the Ohio State Medical Association's Department of Legal Services at (614) 486-2401.

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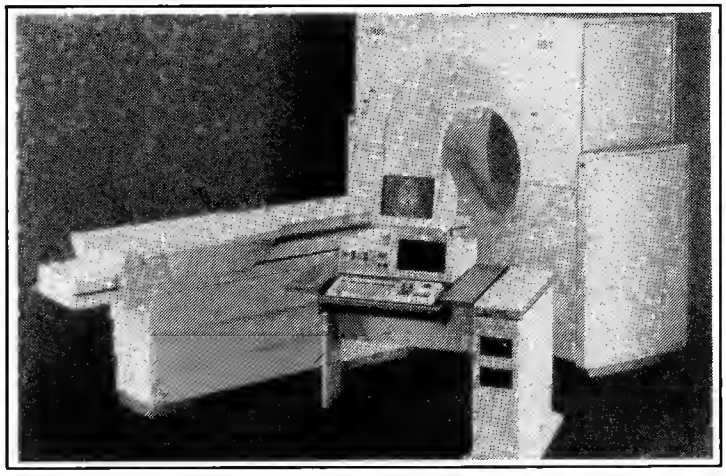

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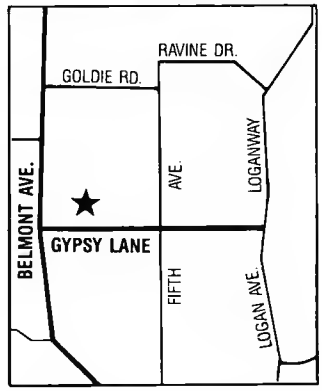

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From the Bulletin

A Look Back . . .

Sixty Years Ago
Jan./Feb. 1934

A new year, and Franklin Roosevelt was making plans to eliminate the depression. New president of the Society was **J.B. Nelson**; Editor of the *Bulletin* was **Claude Norris** and **Sam Tamarkin** was the Business Manager. The Annual Banquet was held in February for $2.00 per person. Morris Fishbein, Editor of the AMA Journal was the speaker.

Fifty Years Ago
Jan./Feb. 1944

We were in the third year of World War II. With 112 members in the armed services, there were only 150 able-bodied members left to carry on the Society's work and tend to the medical needs of the community. **Ivan Smith** was doing physical therapy at Fort Billings, **Clyde Walter** was at Johns Hopkins taking a course in clinical laboratory, courtesy of the U.S. Army, and **A.O. Axelson** was battalion surgeon for an armored tank division in England, getting ready for the Allied invasion of Europe. **Frances Miller** became a new member.

Forty Year Ago
Jan./Feb. 1954

J.D. Brown was the new President. **Ivan Smith**, having survived the war, became President-Elect. **Gabe DeCicco** was secretary and **Andy DeTesco** was the new editor of the *Bulletin*. **Pat Cestone** was certified by the American Board of Surgery, **Jim Calvin** returned from the service to practice Internal Medicine. **Bill Sovik** and **Joe Kupec** were awarded fellowships in the American College of Surgeons, **Stewart Patton** was completing his residency in orthopedics, **Bob Bruchs** opened an office for the practice of OB-GYN, and **Alex Calder** opened his office for the practice of family medicine. New member at that time was **Harold Segall.**

Thirty Years Ago
Jan./Feb. 1964

The new President was **Jack Schreiber**, with **John McDonough** as President-Elect, **R.J. Scheetz** as Secretary and **Bob Warnock** as Editor of the *Bulletin*. **James Calvin** and **Robert Jenkins** were elected to fellowship in the American College of Physicians, and **Robert Wiltsie** was made Diplomate of the American Board of Pediatrics. **Arthur Rappoport** was serving his second year as Governor of the American Society of Pathologists and **Sandford Gaylord** became a member of the Board of Internal Medicine. **Gabe DeCicco** was elected President of the Medical Service Foundation, and **Steve Ondash** started a news bulletin for the Staff of St. Elizabeth Hospital. No new members were reported that month.

Robert R. Fisher, M.D.

Robert R Fisher MD

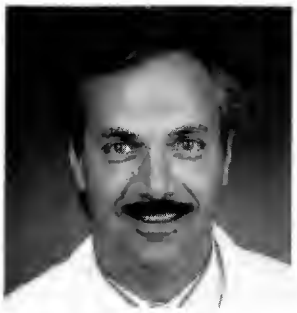
Twenty Years Ago
Jan./Feb. 1974

John C. Melnick was installed as President of the Society, with **Rashid Abdu** as President-Elect. **Y.T. Chiu** was the new Treasurer and **George Dietz** was the new Secretary. **Lou Bloomberg** was the new Editor, and he fired off his first editorial at the members for their poor attendance. **Steve Ondash** was elected as President of the Staff at St. Elizabeth Hospital. Four prominent physicians passed away during this time period. They were: **J.A. "Cash" Altdoerffer, Morris I. Berson, J.U. Buchanan and Edgar C. Baker.** New members were **John H.O. Bleacher, Narciso Domingo, Karol Hoffman, John Tullai** and **Carl Klodell.**

Ten Years Ago
Jan./Feb. 1984

Incoming president was **Glenn J. Baumblatt** with Vice-President **Juan A. Ruiz. Zeev Rabinowitz** was Treasurer and **F.K. Wieneke** was Secretary. New Editor was **Suman K. Mishr.** The theme for the Installation Dinner at the Youngstown Club was "Wine, Wonderful Wine" and the speaker was Arnulf Esterer, owner of Markko Vineyards in Conneaut, Ohio. (Sounds like the beginning of an interesting year.) New members were: **Adele Marie Lipari, Kolli M. Prasad, David H. Smile, Roger J. Hucek** and **Paul A. Wright.** Recently deceased members were **Bertwin E. Einfald**, of a heart attack at age 49; **William Hiram Evans** in Florida at age 85, and **Louis H. Scharf**, of a heart ailment at age 78.

New Members



Robert DeMarco, MD
Pulmonary/Critical Care
Office: 925 Trailwood Drive
Phone: 758-7575
MED. ED: Univ. Auto De Guadalajara, Guadalajara, Mexico
REDCY: Sinai Hospital, Baltimore, MD
INTERN: Sinai Hospital, Baltimore, MD
FELLOW: Univ. of Maryland, Baltimore, MD

Stephanie B. Dewar, MD
Pediatrics
Office: 1044 Belmont Avenue
Phone: 746-7211
MED. ED: University of Pittsburgh, Pittsburgh, PA
REDCY: University Medical Center, Jacksonville, FL
INTERN: University Medical Center, Jacksonville, FL

The following application for membership was approved by Council:

1st Year in Practice
Sayed M. Yossef, M.D.

Information pertinent to the applicant should be sent to the MCMS Council.

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